Blue Sky Acupuncture Studio

PATIENT HISTORY FORM

Patient Information	Contact Information
Name:_____	Home phone:_____
Date:_____	Work phone:_____
Address:_____	Cell phone:_____
ZIP:_____	
Age: _____ Date of Birth:_____	Where can we leave a message for you? Check all that apply.
Occupation:_____	❑ Home ❑ Work ❑ Cell ❑ Email
Primary Physician:_____	Email:_____
Physician phone number:_____	Emergency contact name:_____
How did you hear about us?_____	Relationship:_____
	Emergency contact phone:_____

Health History

Main Complaints

① _____

When did this start?:_____

How often?:_____

Severity?: **1----------|----------10**
5

② _____

When did this start?:_____

How often?:_____

Severity?: **1----------|---------- 10**
5

③ _____

When did this start?:_____

How often?:_____

Severity?: **1----------|---------- 10**
5

List all allergies to foods, medications, etc:

Check conditions you have or have had in the past:

- ❑ Anemia
- ❑ Bleeding disorders
- ❑ Diabetes
- ❑ Dizziness / lightheaded
- ❑ Fainting
- ❑ Heart disease
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV /AIDS
- ❑ Pacemaker
- ❑ Stroke
- ❑ Seizures / epilepsy

Are you pregnant or trying to get pregnant: ❑ Yes ❑ No

Are you taking anti-coagulant medication: ❑ Yes ❑ No

List all medications, herbs and supplements:

Check any symptoms you have now or have had in the past year, and mark an X on the scales.

TEMPERATURE

How warm or cold do you feel (not in degrees)

COLD **HOT**

- ❑ Cold hands or feet
- ❑ Cold "in the bones"
- ❑ Chills
- ❑ No thirst
- ❑ Hot hands, feet, chest
- ❑ Hot flashes
- ❑ Hot in afternoon
- ❑ Hot at night
- ❑ Excessive thirst
- ❑ Night sweats
- ❑ Unusual sweats

MOISTURE

Your overall body moisture

DRY **OILY**

- ❑ Dry skin
- ❑ Dry hair
- ❑ Dry eyes
- ❑ Dry, brittle nails
- ❑ Dry mouth
- ❑ Dry throat
- ❑ Dry nose / nosebleeds
- ❑ Dandruff
- ❑ Psoriasis
- ❑ Edema / swelling
- ❑ Rashes / eczema
- ❑ Oily skin
- ❑ Oily hair
- ❑ Pimples
- ❑ Itchy skin

ENERGY

LOW ---------- **HIGH**

- ❑ Fatigue / tiredness
- ❑ Tired after eating
- ❑ Dependence on caffeine
- ❑ Body / limbs feel heavy
- ❑ Body / limbs feel weak
- ❑ Wired / ungrounded
- ❑ Anxiety
- ❑ Nervousness
- ❑ Irritability

MOOD

- ❑ Anger easily
- ❑ Depression
- ❑ Difficulty concentrating
- ❑ Easily startled
- ❑ Fear
- ❑ Grief
- ❑ Indecision
- ❑ Mental illness
- ❑ Mood swings
- ❑ Sadness
- ❑ Stress
- ❑ Worry

DIGESTION

CONSTIPATION---------- DIARRHEA

- ❑ Dry stools
- ❑ Difficult to pass
- ❑ Alternating diarrhea and constipation (IBS)
- ❑ Loose stools
- ❑ Foul smelling stools
- ❑ Undigested food in stool

Bowel movement: _____ time(s) every _____ day(s)

- ❑ Acid regurgitation / GERD
- ❑ Bad breath
- ❑ Belching
- ❑ Bloating or gas
- ❑ Distention of abdomen
- ❑ Excessive hunger
- ❑ Gallbladder problem
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Liver problem
- ❑ Nausea/Vomiting
- ❑ Poor appetite
- ❑ Stomach pain
- ❑ Ulcers
- ❑ Tired after meals

GENERAL HEALTH

- ❑ Alcoholism
- ❑ Bruise easily
- ❑ Cancer
- ❑ Headaches
- ❑ Poor memory
- ❑ Thyroid problems
- ❑ Weight gain
- ❑ Weight loss

Do you smoke? ❑ Yes ❑ No

SLEEP

- ❑ Difficulty falling asleep
- ❑ Wake up easily
- ❑ Not rested upon waking
- ❑ Disturbing dreams
- ❑ Restless sleep
- ❑ Wake more than once to urinate

Bedtime:
Number of hours per night:

MUSCLE / JOINT / BONES

- ❑ Arthritis
- ❑ Cramps
- ❑ Osteoporosis
- ❑ Paralysis
- ❑ Swollen joints
- ❑ Tremors

Pain / weakness / numbness in:

- ❑ Hands
- ❑ Wrists
- ❑ Elbows
- ❑ Arms
- ❑ Shoulders
- ❑ Neck
- ❑ Upper back
- ❑ Lower back
- ❑ Hips
- ❑ Knees
- ❑ Legs
- ❑ Feet

EAR / NOSE / THROAT / RESPIRATORY

- ❑ Asthma or wheezing
- ❑ Coughing
- ❑ Difficulty breathing
- ❑ Earache
- ❑ Ear ringing
- ❑ Emphysema
- ❑ Enlarged glands
- ❑ Frequent colds
- ❑ Hayfever / allergies
- ❑ Hoarseness
- ❑ Gum problems
- ❑ Mouth sores
- ❑ Nosebleeds
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Sinus problems
- ❑ Sore throat
- ❑ Teeth grinding
- ❑ TMJ / jaw problems

EYES

- ❑ Blurred or failing vision
- ❑ Dry eyes
- ❑ Eye strain or pain
- ❑ Glaucoma
- ❑ Itchy eyes
- ❑ Red eyes
- ❑ Watery eyes

GENITOURINARY

- ❑ Blood or pus in urine
- ❑ Painful or burning urination
- ❑ Frequent urination
- ❑ Unable to control urination
- ❑ Urinary tract infection
- ❑ Kidney stones
- ❑ Kidney disease
- ❑ Lowered sex drive

CARDIOVASCULAR

- ❑ Chest pain
- ❑ Hardening of arteries
- ❑ Palpitations
- ❑ Rapid / irregular heart beat
- ❑ Previous heart attack
- ❑ Poor circulation
- ❑ Varicose veins
- ❑ Dizziness

ANYTHING ELSE WE SHOULD KNOW ABOUT?

FOR WOMEN ONLY

- ❑ Heavy periods
- ❑ Light periods
- ❑ Painful periods / cramps
- ❑ Irregular periods
- ❑ Fatigue with menses
- ❑ Mood changes w/ menses
- ❑ Digestive changes with menses
- ❑ Clots in menses
- ❑ PMS
- ❑ Breast tenderness
- ❑ Midcycle spotting
- ❑ Yeast infections
- ❑ Vaginal discharge
- ❑ Previous miscarriage
- ❑ Use birth control pill

Date of last period:_____

Menopause
Year changes began:_____
Age at last menses:_____

- ❑ Hot flashes
- ❑ Night sweats
- ❑ Vaginal dryness
- ❑ Lowered sex drive

The information on this form is correct to the best of my knowledge.

Signature: **Date:**